Massachusetts Division of Health Care Finance and Policy
2 Boylston Street, Boston, MA 02116
Tel (617) 988-3100 FAX (617) 727-7662 TTY (617) 988-3175

Nursing Facility Quarterly User Fee Assessment Form

Facility Name: _____ **VPN:** _____

Address: _____

City, State, Zip: _____ **Federal Tax ID#:** _____

Contact Name: _____ **Contact Phone#:** _____

The purpose of this form is to gather the necessary information to calculate your facility's User Fee Assessment in accordance with regulation 114.5 CMR 12.04 (1)&(2).

If you have any questions, please call Customer Service at (800) 609-7232.

I. Total Nursing Patient Days for Quarter Ending _____

Only nursing home level days should be included. Do not include resident care days.

	1	2	3	4	5	6		7
Type	**Mass. Medicaid**	**Non-Mass Medicaid**	**MA Comm For the Blind**	**VA/Other Public**	**Private**	**Medicare**		**Non-Medicare Days (Sum(1 – 5))**
Total Qtr NH Patient Days								

II. Calculation of the Nursing Facility User Fee Assessment

Please calculate the user fee below according to your facility's class. See instructions for facility class descriptions.

	Total Qtr Non-Medicare Days (Col. 7 above)		**User Fee Rate**		**NH User Fee**
Class I	_____	X	**11.45**	=	_____
Class II & III	_____	X	**1.15**	=	_____
Class IV	_____	X	**0.00**	=	_____

III. Comments (Attach additional pages if necessary.)

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The facility representative whose signature appears below, is acknowledging to the best of his/her knowledge, by said signature, that the information in this worksheet is true, accurate, and prepared in accordance with applicable regulations and instructions under the pains of penalties of perjury.

_____ _____
Signature of Owner, Partner, Officer or Administrator Date

_____ _____
Print Name of signatory above Print Title